Appealing Denial of Claims

When a claim is denied in whole or in part

If a claim for benefits is wholly or partially denied, notice of the decision shall be furnished to the partner, or in the case of partner life insurance or long-term disability survivor benefits, to the beneficiary. Notice of determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements.

This written decision will:

- Give the specific reason or reasons for the claim determination
- Make specific reference to plan or policy provisions on which the determination is based
- Provide a description of any additional material or information necessary to complete the claim and an explanation of why it is necessary
- Provide an explanation of the review procedure including time limits for appealing the determination, and your right to obtain information about those procedures and the right to sue in federal court, and
- Disclose any internal rule, guidelines, protocol or similar criterion relied on in making the claim determination (or state that such information will be provided free of charge upon request).

You have the right to file a written appeal. During the appeal process, you will have the opportunity to submit written comments, documents or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the initial claim determination will consider all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

If your appeal is denied

If, upon appeal, your request is denied, the denial will contain the following information:

- The specific reason(s) for the appeal determination
- A reference to the specific plan provision(s) on which the determination is based
- A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)
- A statement describing your right to bring a civil suit under federal law, and
- A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination.

Your denial may also contain a statement that, "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Time frames for submitting your appeal

The time frames for filing your written appeal and for the plans', insurance carriers' or claims administrators' consideration and response are outlined on the following page by benefit.

Who Is Your Authorized Representative?

An authorized representative means a person you authorize, in writing, to act on your behalf or a person given authority by court order to submit claims on your behalf. In the case of a claim involving urgent care, a health care professional with knowledge of your condition may always act as your authorized representative.

Filing a health claim appeal (medical, prescription drug, dental, vision, mental health, chemical dependency)

The following pertains to Starbucks self-insured health plans administered though Premera Blue Cross and VSP. If you are enrolled in an HMSA or Kaiser Permanente health plan, refer to your health provider's guide to benefits for health claim appeal procedures.

You (or your authorized representative acting on your behalf) have 180 days following receipt of an adverse benefit determination to file a written appeal.

CLAIMS APPEALS FOR...	SHOULD BE SENT TO...
Medical claims, mental health and chemical dependency claims **Prescription drug claims**	Premera Blue Cross Attn: Member Appeal P.O. Box 91102 Seattle, WA 98111-9202
Dental claims	Premera Blue Cross Attn: Member Appeal P.O. Box 91102 Seattle, WA 98111-9202
Vision claims	VSP Member Appeals 3333 Quality Drive Rancho Cordova, CA 95670 Out-of-Network claims VSP P.O. Box 997105 Sacramento, CA 95899-7105

If the claim involves urgent care, you or your authorized representative may request an expedited review of the claim denial by calling the plan's member services number as shown in the chart below:

PLAN ADMINISTRATION	COVERAGE TYPE	PHONE NUMBER
Premera Blue Cross	Medical, prescription drug, mental health, chemical dependency	(800) 722-1471
Premera Blue Cross	Dental	(800) 722-1471
VSP	Vision	(800) 877-7195

All necessary information, including the appeal decisions, will be communicated between you and your authorized representative and the plan by telephone, facsimile or other similar method. You or your authorized representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your authorized representative and the Plan by telephone, facsimile, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

If you are dissatisfied with the appeal decision on a claim involving urgent care, you can file a second level appeal with Premera Blue Cross. You will be notified of the decision not later than 72 hours after the appeal is received.

What Is Urgent Care?

Urgent care is defined as a sudden illness, injury, or condition that:

- Is severe enough to require prompt medical attention to avoid serious deterioration of the covered person's health
- Includes a condition that would subject the covered person to severe pain that could not be adequately managed without urgent care or treatment
- Does not require the level of care provided in the emergency room of a hospital, and
- Requires immediate outpatient medical care that cannot be postponed until the covered person's physician becomes reasonably available.

For all other denials, you will be notified of the appeal decision not later than 30 days after the request for review is received for services already delivered to the patient (post-service claims).

Second level claims appeal

If you are not satisfied with an appeal decision, you can file a second level appeal within 60 days of receipt of the level one appeal decision. You or your authorized representative may meet the panel in person or, if it is preferred, you may participate by telephone. Notice to you regarding the date and time of the meeting will be given within 30 days of receiving the request. You will be notified of the decision no later than 15 days for pre-service claims or 30 days for post-service claims after the appeal is received. Please note: If your claim involves urgent care, you will be notified of the decision not later than 72 hours after the appeal is received.

Independent review for Premera Blue Cross claims denied based on lack of medical necessity, or claims for services deemed experimental or investigational

You can, at your option, obtain an independent review of a claim denied by Premera Blue Cross when:

- You have exhausted the appeal process for denied claims as outlined above, and you have received a final denial
- The final decision was based upon Premera Blue Cross' determination that the proposed or rendered service or supply is not medically necessary or is experimental or investigational, and
- The cost of the service or treatment at issue, for which you are financially responsible, exceeds $500

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What Is Independent Review?

An independent review is a review by a neutral independent physician with the appropriate expertise in the area at issue, of claim denials based upon lack of medical necessity, or the experimental or investigational nature of a proposed service or treatment.

If you meet the eligibility requirements listed above, you will receive written notice of your right to request an independent review at the time the final decision on your appeal has been rendered. Either you or your authorized representative will be required to submit to Premera Blue Cross the request for Independent Review, subject to verification procedures that the Plan may establish.

Your request for independent review must be submitted to Premera Blue Cross, in writing, within 60 calendar days after you receive the final determination on your appeal.

Upon receipt of your request, Premera Blue Cross will contact an independent review organization (IRO) (medical experts who will then select an independent physician) with appropriate expertise in the area at issue. The independent physician may consider any appropriate credible information submitted by you with the request, and must follow the plan's contractual documents and plan criteria governing the benefits.

You will generally be notified of the independent review decision within 30 days of your request. The notice will state whether the prior Premera Blue Cross determination was upheld or reversed, and briefly explain the basis for the determination. The decision of the external reviewer will be binding on Premera Blue Cross, Starbucks and the Plan.

An expedited review is available when your treating physician certifies that a delay (i.e., waiting a full 30 days) in receipt of the service or treatment would jeopardize your health.

You are responsible for the cost of compiling and sending the information that you wish to be reviewed by the IRO to Premera Blue Cross. Premera Blue Cross is responsible for the cost of sending the information to the IRO and the professional fee charged by the IRO.

Filing a life or accidental dismemberment insurance claim appeal

You, your authorized representative or your beneficiary has 60 days from your receipt of Hartford Life's adverse determination of a life or accidental dismemberment claim to file a written appeal. Your appeal should be sent to Hartford Life at the address provided in Hartford Life's notice.

A decision will be made by Hartford Life no more than 60 days after receipt of the request for review, except in special circumstances (such as the need to hold a hearing), but in no case more than 120 days after the request for review is received. Hartford's written decision will include specific reasons for their decision and specific references to the plan provisions on which the decision is based.

Filing a long-term disability claim appeal

You or your beneficiary (in the case of a survivor benefit) has 180 days from your receipt of Unum's notice of adverse benefit determination to file a written appeal. Your appeal request should be sent to the address provided in Unum's notice.

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The review will be conducted by Unum and will be made by a person different from the person who made the initial determination and such person will not be the original decision maker's subordinate. In the case of a claim denied on the grounds of a medical judgment, Unum will consult with a health professional with appropriate training and experience. The health care professional who is consulted on appeal will not be the individual who was consulted during the initial determination or a subordinate. If the advice of a medical or vocational expert was obtained by the plan in connection with the denial of your claim, Unum will provide you with the names of such expert, regardless of whether the advice was relied upon.

A decision will be made by Unum no more than 45 days after receipt of your request for review, except in special circumstances. If special circumstances require an extension of time to decide your appeal, Unum may extend the review period by an additional 45 days (90 days in total). We will notify you in writing if an additional 45-day extension is needed.

If an extension is needed because you failed to submit the information necessary to decide the appeal, the extension notice will specifically describe the required information and you will have at least 45 days from receipt of the notice to provide it. If you submit the required information within the extension period, Unum will have 45 days from receipt of your information to decide your appeal. If you do not provide the information requested by Unum within the time specified, Unum may decide your appeal without that information.

You will have the opportunity to submit written comments, documents, or other information in support of your appeal. You will have access to all relevant documents as defined by applicable U. S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

A notice that your request on appeal is denied will contain the following information:

(a) The specific reason(s) for the appeal determination

(b) A reference to the specific Plan provision(s) on which the determination is based

(c) A statement disclosing any internal rule, guidelines, protocol or similar criterion relied on in making the adverse determination (or a statement that such information will be provided free of charge upon request)

(d) A statement describing your right to bring a civil suit under federal law

(e) A statement that you are entitled to receive upon request, and without charge, reasonable access to or copies of all documents, records or other information relevant to the determination, and

(f) A statement that "You or your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Notice of the determination may be provided in written or electronic form. Electronic notices will be provided in a form that complies with any applicable legal requirements. Unless there are special circumstances, this administrative appeal process must be completed before you begin any legal action regarding your claim.

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Requesting a reconsideration of a health care and dependent care reimbursement claim

You have 180 days from receipt of Premera Blue Cross' benefit determination to request a reconsideration of a reimbursement claim. Your request should be sent to:

Premera Blue Cross
Attn: Member Appeal
P.O. Box 91102
Seattle, WA 98111-9202

Premera Blue Cross will make a decision within 30 days after receipt of your request for review.

Recovery of Overpayment

If a benefit payment exceeds the amount you are entitled to receive, the plan has the right to require the return of the overpayment on request. Or, the plan may reduce any future benefit payments by the amount of the overpayment.

Assignments

In general, you cannot voluntarily assign your benefit payments under Starbucks benefits plans to anyone other than your health care providers. This prevents garnishments, attachments and voluntary or involuntary assignments for the benefit of creditors.

Subrogation

If you or your enrolled dependents have health care expenses or disability income due to an injury or sickness caused by a third party, your Starbucks benefits plans have certain rights for the recovery of benefits from you or that third party. In this way, the Starbucks plan is protected from paying benefits for a sickness or injury caused by another person or persons.

Starbucks plan has the right of subrogation to all rights of recovery by you or your enrolled dependents against:

- A third party
- Your insurance carrier if there's a claim under the uninsured or underinsured auto coverage provision of an auto insurance policy

The plan has the right to be reimbursed for the amounts it has paid for health care expenses or disability income due to an injury or sickness caused by another party or persons from any amounts you receive by judgment, settlement or otherwise from:

- A third party
- Your insurance carrier
- Any other person or entity, including the auto insurance carrier who provides your uninsured or underinsured auto insurance coverage

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You or your enrolled dependents — or a person authorized by law to represent you if you are not legally capable — must sign and deliver any documents that are required, and do whatever else is necessary or reasonably requested by Starbucks to follow through on the plan's rights of subrogation as described above. The Plan's right to recover from you any amounts received by judgment, settlement or otherwise means that the Plan has a first priority lien to recover from the judgment, settlement or otherwise and all such amounts shall be presumed to be for the recovery of medical expenses. The Plan's first priority lien will apply regardless of whether you or your enrolled dependents are or were made whole from the judgment, settlement or otherwise, whether before or after the Plan's subrogation recovery. The Plan precludes the operation of the "made-whole" and "common fund" doctrines.

Plan Liability

Your Starbucks benefits plans will pay benefits only for expenses incurred while this coverage is in force. Except as described in any extended benefits provision, no benefits are payable for expenses incurred before your coverage has started or after your coverage has ended — even if the expenses were incurred as a result of an accident, injury or death that occurred, began or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

When a single charge is made for a series of services, each service will bear a pro-rata share of the expense. Premera Blue Cross (for medical, dental, prescription drug, mental health and chemical dependency claims) will determine the pro-rata share. Only that pro-rata share of the expense will be considered to have been an expense incurred on the date of such service.

Your ERISA Rights

As a participant in certain benefits plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). ERISA provides that plan participants shall be entitled to:

Receive information about your plan and benefits

- Examine, without charge, at the plan administrator's office and at other specified locations — such as worksites and union halls — all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Upon written request to the plan administrator, obtain copies of all documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and other plan information. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial reports. The plan administrator is required by law to provide each participant with a copy of this summary annual report.
- Receive a copy of the procedures used by the plan for determining a Qualified Medical Child Support Order (QMCSO).

Prudent action by plan fiduciaries

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of your benefits plans. The people who operate your plans, called fiduciaries of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Discrimination

No one, including Starbucks or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining any plan benefit or exercising your rights under ERISA.

Enforce your rights

If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For example, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the plan administrator's control.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the status of a Medical Child Support Order, you may file suit in federal court.

If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees — for example, if it finds that your claim is frivolous.

Questions?

If you have any questions about your plans, you should contact the appropriate plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact:

- The Employee Benefits Security Administration, U.S. Department of Labor, toll-free at (866) 444-EBSA (3272), or
- The Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You can also obtain certain publications about your rights and responsibilities under ERISA by calling the Employee Benefits Security Administration toll-free at (866) 444-EBSA (3272).

You can also find additional information about your rights under ERISA and other important information by visiting the Employee Benefits Security Administration website at www.dol.gov/ebsa.

Your COBRA Rights

If you or your enrolled dependents are no longer eligible for Starbucks group health plan coverage (including your medical, dental, vision, mental health, chemical dependency or health care reimbursement benefits), you may be eligible to continue your group health plan coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA).You pay for the cost of COBRA coverage entirely, plus a small administrative fee. You can receive group health plan benefits for up to 18 or 29 months after you lose coverage, and your enrolled dependents can receive benefits for up to 18, 29 or 36 months.

Eligibility

You and your enrolled dependents may choose to continue your Starbucks group health plan coverage under COBRA, depending on the circumstances under which you lose coverage. To be eligible for COBRA coverage, you or your dependents must be covered under Starbucks group health plans on the date you lose eligibility for that coverage. You don't need to provide evidence of good health to elect COBRA coverage.

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You

As a Starbucks partner covered by the group health plans, you have a right to elect COBRA coverage if you lose your coverage due to one of the reasons, called qualifying events, listed below:

- You terminate employment with Starbucks.
- Your work hours are reduced.
- You were contributing to a health care reimbursement account and move to a position that is not eligible for reimbursement accounts. In this case, you will be able to continue participation in a health care reimbursement account through COBRA.

COBRA coverage may not be available if you are terminated for gross misconduct, including theft.

Military Leave

If you take military leave, you may elect to continue coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). Generally, the procedures for electing, paying for and receiving continuation coverage under USERRA are similar to continuation coverage under COBRA. For more information on military leave and how it may affect your benefit coverage, refer to the Eligibility and Enrollment chapter.

Your spouse or domestic partner

Your spouse or domestic partner is eligible to continue health care coverage under COBRA if he or she loses coverage due to any of the qualifying events listed below:

- You terminate employment with Starbucks.
- Your work hours are reduced.
- You are divorced or legally separated, or you end a domestic partner relationship.
- You become entitled to Medicare benefits.
- You die.

Again, COBRA coverage is not available to your spouse or domestic partner if you are terminated for gross misconduct, including theft.

If you and your spouse or domestic partner both work for Starbucks, and one of you loses group health plan coverage, only the partner who loses group health plan coverage — along with any dependent children who lose coverage because of the event — is eligible for COBRA coverage.

Your dependent children

Your children may be eligible for COBRA coverage if they lose group health plan coverage due to any of the qualifying events listed below:

- You terminate employment with Starbucks.
- Your work hours are reduced.
- You are divorced or legally separated, or you end a domestic partner relationship.
- You become entitled to Medicare benefits.
- You die.

Your children may also be eligible for COBRA coverage if they no longer qualify as a "dependent child" under Starbucks group health plans due to any of the circumstances listed below:

- They reach age 19, unless a full-time student and you have certified their student status.
- They reach age 23, even as a full-time student.
- They get married.
- They are under the custody of your spouse or domestic partner after a divorce or legal separation, unless you are ordered by a court to continue coverage.

COBRA coverage is not available to your dependent children if you are terminated for gross misconduct, including theft.

If your child's group health plan was provided because of a Qualified Medical Child Support Order (QMCSO), and coverage ends because it is no longer required under the order, contact Starbucks Benefits Center at (877) SBUXBEN to find out whether your child is eligible for COBRA coverage.

Are Addresses Up to Date?

Make sure Starbucks has your current address on file, as well as the addresses of your covered dependents if different from yours. If your covered dependent loses eligibility, we need to know where to send a COBRA Notification Letter so your dependent knows his or her available options. It is your responsibility to ensure current addresses are on file for you and your covered dependents. Contact Starbucks Benefits Center at (877) SBUXBEN with any address change information.

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COBRA notification and enrollment

By law, Starbucks is responsible for notifying you or your dependents if you or they lose group health plan coverage due to any of the reasons listed below:

- You terminate employment with Starbucks.
- Your work hours are reduced.
- You become entitled to Medicare benefits.
- You die.

However, you, your spouse or domestic partner, or your dependent child must provide notice to Starbucks Benefits Center at (877) SBUXBEN within 60 days after the qualifying event when your enrolled dependents have lost group health plan coverage due to any of the qualifying events listed below:

- You divorce or legally separate or you end a domestic partner relationship.
- Your child no longer qualifies as a "dependent child" under Starbucks health care plans. Starbucks does not track the marital, student or dependent status or the ages of your children. We will not contact you when your child no longer qualifies for coverage.

If you or your dependent fails to notify Starbucks within 60 days after the qualifying event or, if later, within 60 days after the date coverage is lost, COBRA continuation is not available.

If you cancel your spouse or domestic partner's coverage in anticipation of a divorce or end of a domestic partnership, your spouse or domestic partner will still be eligible for continuation coverage, provided you or your spouse or domestic partner notifies Starbucks Benefits Center within 60 days of the date of divorce or end of a domestic partnership.

After you or Starbucks receive notification of the loss of health care coverage, you'll receive a COBRA Enrollment Notice with instructions on how to elect to continue your group health plan coverage.

Enrollment

If you choose to enroll for COBRA, you or your dependents have 60 days to call Starbucks Benefits Center to make your COBRA elections. The 60-day time frame begins on the day that you receive the COBRA notification letter or the date on which coverage is lost, whichever is later.

If you do not call Starbucks Benefits Center to enroll in COBRA coverage within the 60-day time frame, Starbucks group health plan coverage for you and/or your dependents will end — and COBRA coverage will not be available.

What Is a COBRA Date?

Your COBRA date is the last day of the month in which you qualify for regular Starbucks group health plan coverage. After this date, you'll stop receiving Starbucks coverage and may elect to continue coverage through COBRA, where you pay the entire cost of coverage. A COBRA date may be the last day of the month:

- In which your termination of employment with Starbucks is recorded
- Following the period in which your paid hours are reduced to below eligibility levels for Starbucks benefits coverage
- In which you and your spouse or domestic partner divorce or legally separate
- Before you become entitled to Medicare benefits
- In which you die
- In which your child no longer qualifies as a "dependent child" under Starbucks group health plan

For example, if your last day of work before leaving Starbucks is September 3, your COBRA date is September 30.

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Coverage you may continue under COBRA

If you or your dependents lose group health plan coverage and want to continue it under COBRA, you may elect coverage that is equal to or less than the coverage you had before you became eligible for COBRA coverage.

You have three choices to continue group health plan coverage:

- You may elect to continue the same group health plan coverage you are currently enrolled in.
- You may elect to continue some, but not all, of the group health plan coverage you are currently enrolled in. For example, you may elect to continue only the medical portion of your group health plan coverage. Or, if you have other medical coverage, you may only want to continue your dental coverage.
- You may elect a lower plan option.

Each person eligible for COBRA coverage — you, your spouse or domestic partner or child — may make a separate election to continue coverage or not. Each person chooses which coverage to continue and for how long.

Health care reimbursement account continuation under COBRA

With the health care reimbursement account (HCRA), you elect to pay for your non-covered eligible health care expenses for you and your eligible dependents (if any) with before-tax dollars. You and your enrolled dependents may continue HCRA participation with after-tax dollars until the end of the plan year (September 30) in which your COBRA qualifying event occurs. However, COBRA continuation of HCRA is not available if, as of the date of your COBRA qualifying event, you have been reimbursed from your HCRA more than you have contributed. For example, let's say you elected $2,000 for your HCRA for the year. If, as of your qualifying event you had received

reimbursements totaling $1,000, but you had contributed only $450, then COBRA continuation is not available. This is because you would owe $1,550 in COBRA premiums to maintain your remaining $1,000 benefit.

Dual coverage

If you or your enrolled dependents have coverage under another group health plan on the COBRA date, you may still elect COBRA.

Impact of electing COBRA on other rights

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health plan coverage will affect your future rights under federal law. First, you may lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in group health plan coverage; election of continuation coverage may reduce the likelihood that you would incur such a gap. Second, you may lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not receive continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health plan coverage ends. You will also have the same special enrollment right at the end of continuation coverage if you receive continuation coverage for the maximum time available to you.

When COBRA coverage begins

COBRA coverage starts on the day after the COBRA date. If you receive your COBRA Enrollment Notice after the COBRA date, your COBRA coverage will be retroactive to the day after the COBRA date — provided Starbucks Benefits Center receives your enrollment and payment by the deadlines outlined in this section. Starbucks Benefits Center administers COBRA enrollment and premium collection for all Starbucks health plans, including HMSA, Kaiser Permanente and Vision Services Plan.

Consider COBRA

If you need group health plan coverage after losing your Starbucks coverage, make sure you call Starbucks Benefits Center within 60 days of either the COBRA date or when you receive your COBRA Notification Letter from Starbucks, whichever is later.

Duration of COBRA coverage

You may enroll in COBRA coverage for up to 18 or 29 months depending on your situation. Your enrolled dependents — spouse, domestic partner or children — may enroll for up to 18, 29 or 36 months, depending on your situation. Your COBRA coverage may end however, prior to 18, 29 or 36 months as outlined on pages 260 and 261.

18 months

You and your enrolled dependents may continue group health plan coverage under COBRA for up to 18 months if you lose Starbucks group health plan coverage for one of the reasons listed below:

- You terminate employment with Starbucks.
- Your working hours are reduced.

29 months

You and your enrolled dependents may continue COBRA coverage for up to 29 months — 11 months beyond the initial 18-month coverage period — if any covered family member electing COBRA is disabled on the COBRA date, or becomes disabled during the 60 days following the COBRA date.

The disabled person must meet the Social Security definition of disability as described under Title II or XVI of the Social Security Act. You must provide proof of the disability to Starbucks Benefits Center within 60 days of obtaining Social Security's verification and before the end of the initial 18-month COBRA period.

You must pay higher rates for the additional 11 months of COBRA coverage — 150% of the total cost. COBRA coverage will end on the earlier of these two dates:

- The end of the month in which you are no longer disabled (beyond the 18-month coverage period)
- The end of the 11-month additional COBRA period (29-month total COBRA period)

36 months

Your enrolled dependents may receive up to 36 months of COBRA coverage if one of the following situations occurs during their initial 18 months of COBRA coverage, or if you lost Starbucks benefits eligibility due to one of the situations listed below:

- You divorce, legally separate or end your domestic partner relationship.
- You become entitled to Medicare benefits.
- You die.
- Your child no longer qualifies as a "dependent child" under Starbucks group health plans.

Only your affected dependents may elect to extend their COBRA coverage, after the original COBRA date, up to 36 months due to a second qualifying event. Please contact Starbucks Benefits Center at (877) SBUXBEN within 60 days of the second event if it is a legal divorce or a child no longer qualifying as a dependent.

Cost of COBRA coverage

If you or your enrolled dependents elect COBRA coverage, you must pay the full cost of the group health plan coverage, including what Starbucks paid while you were eligible for benefits or actively employed. Your cost for COBRA is 102% of the total cost. The additional 2% covers the cost to administer COBRA coverage.

If you are disabled and elect to continue COBRA for 29 months, you'll pay an increased premium after the 18th month of coverage. This increased premium is 150% of the total cost. For more information on COBRA coverage during a disability, refer to "29 months" above.

A new COBRA premium rate is determined each October 1 and will be included in your COBRA Notification Letter. Or, you can call Starbucks Benefits Center at (877) SBUXBEN to find out the current COBRA premium rates.

You pay your COBRA premiums on a monthly basis. The monthly premiums start on the first day of the month in which COBRA coverage starts.

When COBRA premiums are due

After you or your enrolled dependents have enrolled in COBRA coverage, you have 45 days to send in your first COBRA premium. This payment must include any COBRA premiums retroactive to your COBRA date — the date you lost Starbucks health care coverage. Partial payments will be accepted if received before 45 days, but the remaining amount must be received by the 45-day deadline to secure elections.

Here's an example of how it works:

- Your COBRA date was January 31.
- You enrolled in COBRA continuation of coverage by March 12.
- You must pay your COBRA premium by April 27, or 45 days after you enrolled.
- Your first payment must include premiums for both February and March — the retroactive months — and April, the current month.
- COBRA coverage will not begin until Starbucks Benefits Center receives your premiums.

Once Starbucks Benefits Center has received your enrollment information, they'll bill you on a monthly basis for future COBRA premiums.

Your premium payments are due by the first day of each coverage month. You are granted a 30-day grace period. Starbucks Benefits Center will not accept payments postmarked after the 30-day grace period has expired.

Here's an example of how it works:

- Your premium for the month of April is due by April 1.
- Your 30-day grace period extends through April 30.
- Starbucks Benefits Center will not accept payments postmarked after April 30.
- Your COBRA coverage ends retroactively on March 31.

What if I Get Sick Before I Receive a COBRA Enrollment Form?

If you receive your COBRA Enrollment Form after the COBRA date, but you or your dependents need to see a doctor before then, go ahead. Your COBRA coverage is retroactive to the day after the COBRA date, provided that Starbucks Benefits Center receives your enrollment form and payment by the deadlines outlined in this section.

When COBRA coverage ends

If you or your enrolled dependents elect COBRA coverage, your group health plan coverage will continue for the 18-month, 29-month or 36-month period described previously.

However, COBRA coverage will end for you or your enrolled dependents — even before the full COBRA coverage period — as soon as any circumstance listed below occurs:

- You resume coverage under Starbucks benefits plans because you re-establish eligibility under the plans.

- You stop making timely payments of your monthly COBRA premiums.
- You or your dependents obtain coverage under another group health plan that doesn't have any pre-existing condition limitations affecting you or your enrolled dependents.
- You or your dependents become entitled to Medicare benefits.
- Starbucks no longer offers group health plan coverage.

For example, if you terminate employment with Starbucks, start working for another company and become covered under that company's group health plan — with no pre-existing condition limitation affecting you — your COBRA coverage under the Starbucks plan will end on the first day of the month following the date your group health plan coverage starts with the other company. See "Certificate of Prior Health Care Coverage" on page 267 for information on how your Starbucks coverage may offset any pre-existing condition limitations.

You must inform us if you or your dependents obtain coverage under another group health plan.

Conversion option

When COBRA coverage ends, you and your enrolled dependents may convert your medical coverage to an individual medical policy with:

- HMSA, if enrolled in the HMSA Preferred Provider Plan
- Kaiser Permanente, if enrolled in a Kaiser HMO plan

Conversion through Premera Blue Cross is not available.

You should know that the coverage and rates of an individual medical policy are significantly different than what may be available through Starbucks plans and COBRA coverage. Dental and vision conversion is not available.

If you've participated in COBRA for the 18-month or 36-month maximum, you'll receive a notification of your conversion rights. You must apply for the medical conversion policy in writing within 30 days to HMSA or Kaiser Permanente – after your COBRA coverage has ended.

Changes in COBRA coverage

If Starbucks changes its group health plan coverage — for example, by increasing deductibles or no longer reimbursing a certain type of expense — COBRA coverage will also change at the same time. In some cases, if you are receiving COBRA coverage, you may be required to switch to another form of group health plan coverage. And, as your COBRA coverage changes, your COBRA premiums may change to reflect the cost of your group health plan coverage.

Starbucks reserves the right to change the terms and conditions of its group health plans and COBRA coverage at any time, subject to applicable legal requirements. Starbucks also reserves the right to terminate COBRA coverage at any time and for any reason, to the extent permitted by law.

Annual open enrollment

At each annual open enrollment for active partners, each person receiving COBRA coverage may elect to change coverage. In addition, each dependent whose coverage started on the COBRA date has the same change options at

open enrollment as active partners. Your enrolled dependents can make different coverage choices from you and your other enrolled dependents.

All changes at open enrollment are subject to the same terms and conditions that apply for active partners. If Starbucks changes the options available at open enrollment, the new options will be explained in the open enrollment materials.

If you or your covered dependent marries, enters into a domestic partner relationship or has a child while covered under COBRA, the new dependent may enroll as a spouse, domestic partner or child under the same special enrollment terms and conditions as active partners eligible for Starbucks benefits.

Coverage for newly acquired dependents continues under the same terms and conditions as the covered person. However, the maximum COBRA coverage period for such new enrollees may not extend beyond the end of the original covered person's maximum COBRA period. Additionally, the newly added dependent will not be able to make a separate election in a subsequent annual open enrollment.

In the case of a new COBRA enrollee who is either a newborn or newly adopted child, the COBRA coverage period will be 18 months, or 36 months if a second qualifying event occurs within their first 18 months of COBRA coverage.

Your Health Privacy Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

The Health Insurance Portability and Accountability Act (HIPAA) requires a health plan to notify plan participants and beneficiaries of its practices to protect the confidentiality of their health information. This notice describes the ways self-insured health benefits within the Starbucks Corporation Welfare Benefits Plan (the "Health Program") may use and disclose health information about you and your rights to review and control disclosure of this information.

The Health Plan needs to create, receive, maintain and disclose records that contain health information about you and your enrolled family members to administer its plan and provide you with health care benefits (e.g., medical, prescription drug, dental, vision, health care reimbursement account). The Health Plan is required by law to maintain the privacy of your health information, to provide you with notice of its legal duties and privacy practices with respect to health information and to follow this notice.

To help protect the privacy of your health information, Starbucks, as the sponsor of the Health Plan, has appointed a Health Privacy Official and developed privacy policies and procedures. Our Health Privacy Official has authority to enforce the health privacy policy at Starbucks.

The Health Plan is required to:

- Protect the privacy of certain health information, and
- Provide you with notice describing its legal duties, your legal rights and its privacy practices with respect to your health information.

This notice is intended to satisfy the notice requirements under the Health Insurance Portability and Accountability Act (HIPAA) with respect to health information created, received or maintained by the Health Plan.

What's included in this notice

The notice outlines how the Health Plan may use or disclose your health information and your rights with respect to your health information. For example, the Health Plan uses your information to facilitate payment of health services. You have certain rights, such as the right to review your health information and suggest correction of any errors.

Use and disclosure

The following are the different ways the Health Plan may use and disclose your health information. Most of these disclosures are not made to or from Starbucks, but to and from your health care providers and the Health Plan's third-party administrators who facilitate payment and other health care operations (e.g., Premera Blue Cross and others). Not every use or disclosure in a category is listed, but the ways in which the Health Plan is permitted to use and disclose information falls within one of the categories.

- **For treatment.** Your health information may be disclosed to health care providers including doctors, nurses, laboratory technicians, medical students and other health care personnel involved in your treatment. For example, the Health Plan may disclose your prescription medication information to a pharmacy to identify potential adverse drug reactions.
- **For payment.** Your health information may be disclosed so claims for health care treatment, services and supplies you receive from health care providers may be paid according to the Health Plan's terms. For example, the Health Plan may receive and maintain information about surgery you received to allow the Health Plan to process a hospital's claim for reimbursement of surgical expenses resulting from your surgery.
- **For health care operations.** The Health Plan may use and disclose your health information to enable it to operate more efficiently or verify that all of the Health Plan's participants receive their health benefits. For example, the Health Plan may use your health information for patient care management or to perform population-based studies designed to manage health care costs. In addition, the Health Plan may use or disclose your health information to conduct compliance reviews, audits, actuarial studies and/or for fraud and abuse detection. The Health Plan may also combine health information about many Health Plan participants and disclose it to Starbucks in summary fashion so that it can decide what coverages the Health Plan should provide.
- **To Starbucks as plan sponsor.** The Health Plan may disclose your health information to designated Starbucks partners so they can carry out their Health Plan-related administrative functions, including the uses and disclosures described in this notice. Such disclosures are to designated members of the Health Privacy Office, who are required to safeguard your health information.
- **To a business associate.** Certain services are provided to the Health Plan by third party administrators and other third parties known as "business associates." For example, the Health Plan may enter information about your health care treatment into an electronic claims processing system maintained by the Health Plan's business associate so your claim may be paid. In doing so, the Health Plan will disclose your health information to its business associate so it can perform its claims payment function. However, the Health Plan will require its business associates, through contract, to appropriately safeguard your health information.

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- **As required by law.** The Health Plan will disclose your health information when required to do so by federal, state or local law, including those that require the reporting of certain types of wounds or physical injuries.
- **Treatment alternatives and health-related benefits and services.** The Health Plan may use and disclose your health information to tell you about possible treatment options or alternatives and health-related benefits and services that may be of interest to you.
- **Individuals involved in your care or payment of your care.** The Health Plan may disclose your health information to a close friend or family member involved in or who helps pay for your health care. The Health Plan may also advise a family member or close friend about your condition, your location (for example, that you are in a hospital) or your death.

Other use and disclosure situations

The Health Plan may also use or disclose your health information in accordance with the law:

- To facilitate organ or tissue donation or transplantation, if you are an organ or tissue donor
- To the military command authorities if you are a member of the armed forces and the information is deemed necessary
- To workers' compensation carriers to the extent necessary to comply with workers' compensation laws
- To public health agencies for public health activities (for example, to avert a serious threat to health or safety; to prevent or control disease, injury or disability; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and to report reactions to medications or problems with products)
- For law enforcement purposes (for example, to identify or locate a suspect, material witness or missing person)
- To coroners, medical examiners or funeral directors (for example, to identify a person or cause of death)
- For national security and intelligence agencies (for example, for intelligence, counterintelligence and other national security activities authorized by law, and to enable them to provide protection to certain individuals or conduct special investigations)
- To correctional institutions or law enforcement officials if the person is in custody
- To a health oversight agency for audits, investigations, inspections and licensure needed for the government to monitor the health care system
- To law enforcement officials about victims of abuse, neglect or domestic violence
- For judicial and administrative proceedings (such as to respond to court orders or subpoenas)
- For research purposes in limited circumstances
- For other uses and disclosures that are outside of the categories described in this notice, but only with your written authorization. Generally, if you authorize the plan to use or disclose your health information, you may revoke the authorization, in writing, at any time.

Your rights

You have rights with regard to your health information. If you wish to exercise any of the following rights, please contact the Starbucks Benefits Department and Health Privacy Office through the Partner Contact Center at (866) 504-7368. Specifically, you have the right to:

- **Inspect and copy your health information.** To review your health information that is in the possession or under the control of the Health Plan, and to obtain a copy of such information, you must make your request in writing and pay a reasonable fee for the copies. In certain circumstances, the Health Plan may deny your request to review your health information.
- **Request to amend your health information.** If you believe your health information is incorrect or incomplete, you may ask the Health Plan to amend the information if it is information that is kept by or for the Health Plan. In certain situations, the Health Plan may deny your request to amend your health information.
- **Receive a record of disclosures of your health information.** You have the right to request an accounting of certain disclosures of your health information, but the request cannot include dates before April 14, 2003.
- **Restrict disclosure of your health information.** You have the right to request a restriction or limitation on how the Health Plan uses or discloses your health information for treatment, payment, health care operations or to those involved in your care or payment for your care. For example, you could ask that the Health Plan not use or disclose information about a specific surgery that you had. Note: The Health Plan is not required to agree to your request.
- **Request confidential communications.** You have the right to request that the Health Plan communicate with you about health matters in a certain way or at a certain location. For example, you can request that the Health Plan only contact you by mail. The Health Plan will accommodate your reasonable requests.
- **Obtain a copy of this notice.** You have the right to obtain a paper copy of this notice upon request.
- **File a complaint.** If you believe your privacy rights have been violated, you may complain to Starbucks by contacting the Starbucks Benefits Department and Health Privacy Office through the Partner Contact Center at (866) 504-7368, or by writing to Starbucks Health Privacy Office, Starbucks Corporation, Mailstop S-HR3, P.O. Box 34067, Seattle, WA 98124-1067. You may also file a complaint with the Federal Department of Health and Human Services. The Health Privacy Official will assist you. We will not retaliate against you for filing such a complaint.

Changes to this notice

The Health Plan reserves the right to change the privacy practices described in this notice, in accordance with the law. Changes to our privacy practices would apply to all health information we maintain. If we change our privacy practices, you will receive a revised notice mailed to your home address. Until such time, the Health Plan will comply with this notice.

Specially protected health information

Federal and state law may impose additional privacy and confidentiality restrictions on the use and disclosure of mental health, AIDS/HIV, drug addiction, alcoholism, and other chemical dependency treatment, developmental disabilities and/or genetic information and records.

Contact information

If you have questions, please contact the Starbucks Benefits Department and Health Privacy Office through the Partner Contact Center at (866) 504-7368, or write the Health Privacy Office at Starbucks Corporation, Attn: Health Privacy Office, Mailstop S-HR3, P.O. Box 34067, Seattle, WA 98124-1067.

Representations

Starbucks will not use or further disclose protected health information (PHI) received from the Health Program other than as permitted or required by the above notice. Further, Starbucks will:

- Ensure that any agent, including a business associate or subcontractor to whom it provides PHI received from the Health Program, agrees to the same restrictions and conditions that apply to Starbucks with respect to such PHI.
- Not use or disclose PHI received from the Health Program for employment-related actions and decisions or in connection with any other benefit or benefits plan of Starbucks (or its affiliates).
- Report to the Health Privacy Office any use or disclosure of PHI received from the Health Program that is inconsistent with the permitted uses or disclosures of which it becomes aware.
- To the extent required by HIPAA, allow Health Program participants to access their own PHI received from the Health Program, consider (and incorporate, where appropriate) participant-requested amendments to such PHI and, upon request, provide Health Program participants with an accounting of the disclosures of their PHI.
- Make Starbucks internal practices, books and records relating to the use and disclosure of PHI received from the Health Program available to the U.S. Department of Health and Human Services for purposes of determining the Health Program's compliance with HIPAA.
- If feasible, return or destroy all PHI received from the Health Program that Starbucks still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

Starbucks will provide adequate firewalls, in accordance with HIPAA, between the Health Program and the components comprised of the remaining benefits provided under the Plan (i.e., the fully-insured group health plan benefits and non-group health plan benefits).

In addition, Starbucks will ensure that it is adequately separated from the Health Program. Accordingly, Starbucks will restrict access to PHI to partners who (1) perform functions directly on behalf of the Health Program or (2) have access to PHI on behalf of Starbucks for its use in Health Program administrative functions. Such partners may use and disclose PHI for Health Program administrative functions, and they may disclose PHI to other such partners for Health Program administrative functions (but the PHI disclosed must be limited to the minimum amount necessary to perform the Health Program administrative function). Such partners may not disclose PHI to partners other than those described in the foregoing sentence except as permitted by HIPAA. Sanctions for using or disclosing PHI in violation of these provisions may be imposed in accordance with Starbucks discipline policy, up to and including termination.

To the extent required by HIPAA, Starbucks will implement steps to reasonably and appropriately safeguard electronic protected health information ("ePHI") created, received or maintained on behalf of the Health Program, as well as policies and procedures to ensure that its creation, receipt, maintenance, or transmission of ePHI complies with the applicable administrative, physical, and technical safeguards required to protect the confidentiality and integrity of ePHI.

Starbucks will ensure that adequate separation between the Health Program and the components comprised of the remaining benefits provided under the Plan and between the Health Program and Starbucks be maintained and supported by reasonable and appropriate security measures. Starbucks will ensure that any agent, including a business associate or subcontractor, to whom Starbucks provides ePHI received from the Health Program agrees to the same restrictions and conditions that apply to Starbucks with respect to such ePHI. Starbucks will further require any agents, including a business associate or subcontractor, to whom Starbucks provides ePHI received from the Health Program, to notify Starbucks of any security incident as defined under HIPAA.

Health information not covered by this notice

The notice does not apply to certain activities listed below, although other protections may apply:

- Any health information you or your health care provider submits to Starbucks for workers' compensation claims, leave of absence eligibility and short- and long-term disability benefits
- Employment-related activities, such as drug testing and fitness-for-duty physicals

Please recognize that health information you voluntarily disclose to your coworkers, supervisor or manager, Partner Resources generalist or Starbucks Business Conduct Helpline is not protected by the nature of your volunteering this information.

You should receive a separate notice of privacy practices from your health care providers, such as your physician, that will describe their privacy practices.

Certificate of Prior Health Care Coverage

The group health plan coverage you obtain after you leave Starbucks may have a pre-existing condition limitation. Under the Health Care Insurance Portability and Accountability Act (HIPAA) you may be able to shorten or eliminate that limitation if you can show that you had previous group health plan coverage. But, if the gap between the date you lose your coverage under Starbucks group health plan — including COBRA coverage — and the date when coverage starts under your new plan is 63 days or more, you may lose the right to take credit for your previous group health plan coverage.

When you lose eligibility for group health plan coverage, a certificate will be mailed to you detailing your prior group health plan coverage under Starbucks benefits plans shortly after your benefits end. You'll want to keep this certificate for future reference. By presenting it at the time you enroll under a new group health plan, you may reduce the amount of time you need to wait before you are covered for certain pre-existing conditions. Contact Starbucks Benefits Center at (877) SBUXBEN for more information.

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Qualified Medical Child Support Order

A Qualified Medical Child Support Order (QMCSO) is a court order compelling a parent to enroll a child in the employer's group health plan. A QMCSO may be issued as part of a divorce proceeding or court-ordered child support.

A QMCSO must include:

- Your name and last known mailing address, as well as the name and address of each child covered by the QMCSO (except the name and mailing address of the appropriate government agency may be substituted for the address of the child)
- A reasonable description of the type of coverage to be provided by the plan for each child, or the manner in which the type of coverage is determined
- The period to which the QMCSO applies

When Starbucks Benefits Department receives a medical child support order, it will promptly notify you and each child named in the order. Starbucks will inform all parties what Starbucks procedures are for determining whether the order is a QMCSO. If it's determined that the court order is a QMCSO, and the child is enrolled, you may incur additional payroll deductions.

Starbucks Benefits Department will promptly decide whether the order is a QMCSO and notify you and each child of its decision.

The child named in the QMCSO will be treated as a covered dependent under the Plan. Any benefit paid under a QMCSO to reimburse a child or the custodial parent or legal guardian will be made to the child or to that custodial parent or legal guardian.

Participants and beneficiaries can obtain, without charge, a copy of the procedures governing qualified medical child support order determinations by contacting Starbucks Benefits Department through the Partner Contact Center at (866) 504-7368.

Questions?

To find out more about your rights and responsibilities under Starbucks benefits plans, call Starbucks Benefits Center at (877) SBUXBEN.

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